

LICENSE RENEWAL AFFIDAVIT FOR NURSING HOME ADMINISTRATORS**PLEASE PRINT CLEARLY IN INK OR TYPE**

Please complete and return License Renewal Affidavit Form to NHAP address listed below.

NHA LICENSE NO.**LICENSE STATUS****\$25.00** FOR LICENSE STATUS CHANGE ONLY**LICENSE RENEWAL FEES**If application and payment are received by your license expiration date, the fee will be **\$190.00**.If application and payment received after the license expiration date, add an additional **\$50.00**.**PLEASE NOTE**

If your license has been expired for two (2) or more years, please contact the NHAP office at (916) 552-8780 or by electronic mail at NHAP@dhs.ca.gov for your renewal fee quote.

☐ ACTIVE ☐ INACTIVE

LAST NAME OF ADMINISTRATOR		FIRST NAME OF ADMINISTRATOR		MIDDLE NAME
ADDRESS		CITY	STATE	ZIP CODE
TELEPHONE NUMBER		SOCIAL SECURITY NUMBER		

CONTINUING EDUCATION

- ☐ I HAVE SUCCESSFULLY COMPLETED 40 HOURS OF CONTINUING EDUCATION DURING MY LAST LICENSE PERIOD AND WANT AN ACTIVE LICENSE.
- ☐ I HAVE NOT COMPLETED THE CE REQUIREMENTS AND WANT AN INACTIVE LICENSE*
(I understand that I cannot practice as a nursing home administrator in California with an inactive license)

CONVICTIONS

SINCE YOU LAST RENEWED YOUR LICENSE, HAVE YOU BEEN CONVICTED OF OR PLED NOLO CONTENDERE TO ANY VIOLATION OF ANY LAW OF ANY STATE, THE UNITED STATES OR A FOREIGN COUNTRY? YOU MUST DISCLOSE ALL MISDEMEANOR AND FELONY CONVICTIONS (INCLUDING BUT NOT LIMITED TO CIVIL, WELFARE, HEALTH AND SAFETY, VEHICLE OR PENAL CODE CONVICTIONS) AND ANY CONVICTION WHICH HAS BEEN DISMISSED (UNDER SECTION 1203.4 OF THE PENAL CODE.)

☐ YES ☐ NO

COMPLETE **ONLY** IF A CHANGE IN NAME OR ADDRESS HAS OCCURRED PRINT ANY CORRECTIONS BELOW
(Attach appropriate documentation verifying the change e.g., copy of driver's license, marriage license, passport, etc.)

LAST NAME		FIRST NAME		MIDDLE NAME
MAILING ADDRESS		CITY	STATE ZIP CODE	TELEPHONE NUMBER

CERTIFICATION—IMPORTANT—PLEASE READ BEFORE SIGNING—If not signed, this application may be rejected.

I certify under penalty of the perjury laws of the State of California that the information I have entered on this application is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this license application by the Nursing Home Administrator Program (NHAP). I fully understand that NHAP may require additional documentation prior to approving and issuing a duplicate license.

APPLICANT'S SIGNATURE **

DATE SIGNED **

FOR NHAP OFFICE USE ONLY

Check No. _____ Check Amount _____ NHAP Initials _____

Return this form to: NHAP, P.O. Box 997416, MS 3302, Sacramento, CA 95899-7416